



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SCOTT & WHITE HOSPITAL MEDICAL CENTER 2401 SOUTH 31 ST STREET TEMPLE TX 76508	MFDR Tracking #: M4-10-4676-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: DEEP EAST TEXAS SELF INSURANCE Box #: 42	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid to fee schedule."

Amount in Dispute: \$4,311.06

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the Medical Fee Dispute Resolution Request Form DWC Form 60 requested by Scott & White Memorial Hospital. Based on the submitted documentation, an allowance of \$228.43 is being recommended."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
03/19/2009	HCPCS Code A6258	$\$4.52 \times 1.25\% = \$5.65 - \$5.54$ (carrier payment)	\$3.50	\$0.11
03/19/2009	CPT Code 73650-LT	$\$41.54 \times 200\% = \$83.08 - \$84.10$ (carrier payment)	\$31.17	\$0.00
03/19/2009	CPT Code 76000	N/A	\$154.67	\$0.00
03/19/2009	CPT Code 28300-LT	$\$2,903.42 \times 200\% = \$5,806.84 - \$2,626.67$ (carrier payment)	\$3,232.70	\$3,180.17
03/19/2009	CPT Code 27698-LT	$\$917.27 \times 200\% = \$1,834.54 - \$1,313.33$ (carrier payment)	\$665.94	\$521.21
03/19/2009	CPT Code 64450	N/A	\$224.08	\$0.00
			Total Due:	\$3,701.49

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on July 12, 2010.

According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Tex. Lab. Code Ann. §413.011(d-3) states that the division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On January 11, 2011 the division requested a copy of the contract between the network and the health care provider. On January 13, 2011 the division received a response from the insurance carrier stating that no informal/voluntary discount was taken for the date of service 03-19-09; the response went

on to state that no contract is applicable. Therefore the disputed health care will be reviewed in accordance with §134.403.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - 45 – Charge exceeds fee schedule/maximum allowable or contract/legislated fee arrangement.
 - W1 – Workers Compensation State Fee Schedule adjustment.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 97 – The benefit for this service is included in the payment /allowance for another services/procedure that has already been adjudicated.
2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that “Regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables.”
3. Pursuant to Division rule at 28 TAC §134.403(f), “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 200 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.”
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. According to Medicare, HCPCS Code A6258 is a Status A code. Status A codes are paid under a fee schedule or with a prospectively determined rate. In accordance with 134.203(d)(1) the MAR for HCPCS Level II codes shall be determined at 125 percent of the fee listed for the code in the Medicare DMEPOS schedule. Therefore, additional reimbursement is recommended.
6. CPT Code 73650-LT is a Status X code. Status X codes are considered ancillary services, paid as APCs rather than from a fee schedule. No additional reimbursement is recommended.
7. CPT Code 76000 is a Status N code. Status N codes are services or procedures included in the APC rate, but not paid separately (this is a packaged item). No additional reimbursement is recommended.
8. CPT Code 27698-LT was listed on the table of disputed services as 27688-LT. Since the CPT Code 27698 –LT was the code listed on the UB-04, it appears a typographical error was made on the table of disputed service.
9. CPT Codes 28300-LT, 27698-LT and 64450 are Status T codes. Status T codes are considered outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. Additional reimbursement is recommended for CPT codes 28300-LT and 27698; however according to Medicare CCI edits CPT code 64450 is excluded by both CPT codes 27698 and 28300. No additional reimbursed is recommended for code 64450.
10. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
 - (1) No documentation was found to support a contractual agreement between the parties to this dispute;
 - (2) MAR can be established for these services; and
 - (3) Separate reimbursement for implantables was NOT requested by the requestor.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is \$3,701.49.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.203, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$3,701.49 plus accrued interest per Division rule at 28 TAC §134.130 and §413.019 (if applicable), due within 30 days of receipt of this order.

DECISION/ORDER:

_____	_____	March 14, 2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.